Is your problem the result of a work related accident? (check one) _________ Yes _________ No
Is your problem the result of a motor vehicle accident? (check one) _________ Yes _________ No

MEDICAL HISTORY:

Name: ______________________ D.O.B.: __________ Age: _____ Date: __________

Referred By: ______________________ Primary M.D.: ______________________

Reason for today's visit: ______________________

When did the problem begin? ______________________

List any surgeries: ______________________

Current Medications: List all medications that you take regularly or check _________ None

____

____

ALLERGIES: _______ Penicillin _______ Aspirin _______ Latex _______ Iodine _______ Shellfish _______ None
List any other allergies to medications that you have:

PAST MEDICAL HISTORY: *check any health problems old or new*

______ Bleeding Problems	______ Hepatitis	______ Seizures	______ Phlebitis
______ High Blood Pressure	______ Liver Disease	______ Diverticulitis	______ Anemia
______ Heart Problem/Chest Pain	______ Kidney Disease	______ Thyroid Problems	______ Stroke/TIA
______ Chronic Pulmonary Disease	______ Cancer	______ Parkinson	______ Ulcers
______ Shortness of Breath	______ Diabetes	______ Arthritis	______ Venereal Disease
______ Asthma	______ Lupus	______ Gout	Other: ______
______ Colitis			

REVIEW OF SYSTEMS:

General: __________ Weight Gain or Loss Other: ______________________
Head: ______ Headaches ______ Blackouts ______ Dizziness Other: ______________________
Eyes/Ears/Nose/Throat: ______ Double Vision ______ Nosebleeds Other: ______________________
Heart: ______ Chest Pains ______ Palpitations ______ Heart Attack ______ Heart Failure Other: ______________
Lungs: ______ Shortness of Breath ______ Cough Other: ______________________
Bowels/Abdomen: ______ Bloody Stool ______ Pain Other: ______________________
Urinary Tract: ______ Bloody Urine ______ Infections ______ Pain Other: ______________________
Circulation: ______ Bloody Clots ______ Pain Other: ______________________
Musculoskeletal: ______ Pain ______ Limitation of Movement ______ Paralysis ______ Weakness ______ Injury Other: ______
Neurological: _____ Stroke _____ Dizziness _____ Paralysis _____ Weakness _____ Injury Other: ___________
Skin: _____ Rash _____ Lumps Other: ______________________
_____ Check here if you are having none of these problems Height: _________ Weight: _________

FAMILY HISTORY: *check or list any medical problems that run in your family*
______ Arthritis ______ Heart Disease ______ High Blood Pressure ______ Diabetes ______ None Other: __________

SOCIAL HISTORY:

Occupation: ______________________ Marital Status: _____ Single _____ Married _____ Widow _____ Divorced
Living Arrangements: _____ Self _____ With Spouse Other: ______________________
Alcohol Use: _____ Never _____ Occasional _____ Frequent
Tobacco Use: _____ No _____ Yes How much? ______________ How long? ______________